STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 08/24/2	LETED	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO 87TH AVE LLVILLE, IN46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Complaint IN00 Complaint Number substantiated, Fe related to the alled 157, F 225, F 225 Survey Dates: At 2011. Facility Number Provider Number Aim Number: Survey Team: Marcia Mital, RN Census Bed Type SNF: 38 Residential: 63 Total: 103 Census Payor Ty Medicare: 32 Other: 71 Total: 103 Sample: 4 Residential Sample: 4 Residential Sample: 4	per: IN0094788 deral/state deficiencies regations are cited at F 6, F 323, and F 514. ugust 19, 22, and 24, 1010739 11: 155764 11: N/A N, TC 12: 15: 15: 15: 15: 15: 15: 15: 15: 15: 15	F0000	The submission of this Correction does not in admission by Spring M Campus that the findir allegations contained accurate and true reprof the quality of care a provided to the resided Spring Mill Health Carfacility recognized it's provide legally and menecessary care and seresidents in an econor efficient manner. The hereby maintains it is substantial compliance requirments of particip comprehensive health facilities (for Title 18/1 programs). To this end of correction shall send credible allegation of with all state and fede requirements governir management of this fathus submitted as a mistatue only.	dicate an dill Health higs and herin are resentations and services his of hipus. This obligation to edically ervices to its mic and facility in e with the bation for care 9 d, this plan we as the compliance ral hig the acility. It is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JCEF11

Facility ID:

010739

TITLE

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
		155764	A. BUII B. WIN			08/24/2	
	PROVIDER OR SUPPLIER		B. WIIN	STREET A	DDRESS, CITY, STATE, ZIP CODE 37TH AVE LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ce with 410 IAC 16.2 completed on August 29, lkner, RN					
F0157 SS=D	resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical tertreatment significant conditions or clinical tertreatment significant change mental, or psychosocial statuconditions or clinical tertreatment significant reatment significant facility and treatment significant facility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) of the facility must resident's legal registent's legal registen	s in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due uences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the own, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or int rights under Federal or ations as specified in	F0	157	1. Resident B's physician an	d	09/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JCEF11

Facility ID:

010739

If continuation sheet

Page 2 of 21

l i					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155764	B. WIN			08/24/2011	
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			101 W 8	87TH AVE		
	MILL HEALTH CAN				LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	1	TAG		DATE	
	1 *	ensure a resident's			family were notified. There w no negative outcome noted.2		
	physician and family member were				Current residents with change	l l	
		tear in a timely manner			injuries, etc. are at risk for all	•	
	for 1 of 4 residen	its reviewed for physician			deficiency. Current residents		
	and family notifi	cation in a total sample			change of conditions, injuries		
	of 4. (Resident B				and/or circumstance forms w		
	Findings include	:			reviewed by DHS or designee for physician and family notification. Notification will be made accordingly for any incidents identified to be out of		
	Resident B's reco	ord was reviewed on					
	8/10/11 at 12:45 n m. Posident Pla						
	diagnoses included, but were not limited				will in-service nurses on phys and family notification per fac		
	~	pertension and anemia.			policy.4. Change of condition		
	,,,,,,				circumstance forms and injur		
	A "skin imnairme	ent circumstance" form,			etc. will be reviewed daily for		
		dicated the resident had a			timely notification. Trends will		
	· ·	ght forearm. There was a			brought to QA for 6 months or until 100% compliance is	01	
		tation on the form to			achieved.5. 9/23/11		
		lent's physician or family					
	had been notified	of the skin tear.					
	The resident's nu	rses' notes, lacked					
	documentation of	f an entry for 7/16/11.					
	A physician's ord	ler, dated 7/18/11,					
	1	bacitracin to S.T. (skin					
	1	FA (forearm) et (and)					
		y dressing dly (daily)."					
	15.01.0 (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, w.j (wwi.j).					
	During an intervi	iew on 8/19/11 at 1:45					
	p.m., LPN #1 inc	licated the physician was					
	not notified of th	e skin tear for two days.					
		d when he came into					
	work on 7/18/11	he called the physician					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155764		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/24/2011	
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE LLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	he was unable to	find anything which			
	fag REGULATORY OR LSC IDENTIFYING INFORMATION) for a treatment order. LPN #1 indicated he was unable to find anything which indicated the family had been notified of				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155764	B. WING	<u> </u>	08/24/2011
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER		ı	87TH AVE	
SPRING	MILL HEALTH CAM	1PUS		LLVILLE, IN46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=D	have been found of or mistreating resistance had a finding nurse aide registry mistreatment of resistreatment of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State concerning abuse, neglect, esidents or misappropriation and report any knowledge it a court of law against an awould indicate unfitness for eaide or other facility staff to			
	authorities. The facility must e violations involving abuse, including ir and misappropriat reported immediat the facility and to with State law thro (including to the Sagency).	ensure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are rely to the administrator of other officials in accordance ough established procedures tate survey and certification			
	alleged violations and must prevent the investigation is				
	reported to the adding representative and accordance with Sistate survey and working days of the	nvestigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 ie incident, and if the alleged d appropriate corrective sen.			
	Based on observation interview, the faction in investigation origin and failed	ation, record review, and cility failed to complete for injuries of unknown to notify ISDH (Indiana t of Health) of the	F0225	Facility completed investig on Resident B and notified IS (Indiana State Department o Health) at the time of survey There was no negative outco noted.2. All residents are at	SDH f ome

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
THEFTE	or connection	155764	A. BUIL			08/24/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	2			B7TH AVE		
	MILL HEALTH CAN	MPUS			LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	COMPLETION DATE
IAG	+	4 residents reviewed for		IAG	for alleged deficiency.		DATE
	1 3	own origin in a total			Investigations for incidents	of	
	sample of 4. (Re	•			unknown origin will be revi		
	Sample of 4. (K)	esident B)			for thoroughness and appr		
	Findings include	··			notification to ISDH (Indiar Deparment of Health) by D		
	Tilldings include				designee. Additional invest		
	Resident B's rec	ord was reviewed on			or reporting will be comple		
		p.m. Resident B's			accordingly.3. DHS or design will in-service nurses on	yıı ce	
		led, but were not limited			investigation procedures p	er	
	1	pertension and anemia.			facility policy and state reportable		
	A quarterly MDS (Minimum Data Set)				guidelines. Nurses will be required to notify Administr	ator or	
					designee of situations requ		
	assessment, date	ed 8/5/11, indicated the	1 11.9 11.1 11.1 9		-		
	resident had sev	ere cognitive impairment.			designee will review		
					investigations within 24 ho the incident and report to I		
	An accident/inci	dent report, dated 8/16/11			accordingly. Trends will be		
	at 7:00 a.m., ind	icated "the resident was			brought to monthly QA x 6		
	found with bruis	ing to nose, sides of			months or until 100% comp	oliance	
	mouth, lip tear	Describe Injuryskin tear			is achieved.5. 9/23/11		
	and bruise small	in size (indicated by					
		Additional Information					
		en with redness to nose					
	1 -	f mouth and lip with skin					
	1	d." The Incident/Accident					
	investigation wa	s left blank.					
	Resident B was	observed on initial tour					
		8/19/11 at 8:50 a.m.,					
		eelchair in the dining					
	_	s a scabbed area to the					
	resident's lower	lip on the left side and a					
		vellow in color to the					
	1	ext to his mouth. The tip					
		nose was brownish red in					

010739

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	ETED
		155764	B. WIN			08/24/20)11
					ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER			101 W 8	87TH AVE		
	MILL HEALTH CAM	IPUS		MERRII	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	-	DATE
		ndicated the resident had					
	_	the yellow bruise to the					
	resident's face was new.						
		ndition Form" dated					
	8/16/11, indicated "7:15 aResident						
	was seen with tip	of nose reddish/bruised					
	both sides of mo	uth with red marks, lip					
	reddish skin tear	and extremely aggitated					
	(sic)" The follow	ow up assessments for					
	8/16/11 the 3-11	shift and 8/16/11 the					
	11-7 shift were b	lank and lacked					
	assessments. Th	e last documentation of					
	11-7 SHIILS OH 8/1	16/11.					
	During an intervi	iew on 8/19/11 at 1:24					
	l ⁻	-					
		-					
		3					
		•					
		•					
	on wednesday at	iu askeu wiiai nappeneu.					
	During an intervi	iew on 8/19/11 at 1:55					
	p.m., the Directo	r of Nurses (DON)					
	indicated she wo	uld have to check with					
	LPN #1 for the in	vestigation. She					
		estigation should have					
	assessments. The an assessment was 7-3 shift. There documentation of 11-7 shifts on 8/1 1	lank and lacked e last documentation of as dated 8/18/11 on the was a lack of f an assessment for the 7/11 and the 3-11 and 18/11. liew on 8/19/11 at 1:24 cated an investigation be done by the nurse on e injuries were found. e had seen the yellow ident's face when she had esday 8/17/11. She ident's son had come in and asked what happened. liew on 8/19/11 at 1:55 r of Nurses (DON) uld have to check with avestigation. She					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155764	B. WING		08/24/2011
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP CODE 87TH AVE ILLVILLE, IN46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	been on the incidindicated the area reported to ISDH started because of located. Resident B was of 2:10 p.m., with I measured the area nose, and bruise mouth. The area was 1.8 centimeter and was reddish/resident's left che by 1.7 centimeter color. The reside was 3.2 by 0.2 ce indicated he had of how the areas documented in a unable to find the	lent report. The DON as should have been I and an investigation of where the areas were observed on 8/19/11 at LPN #1 present. LPN #1 as to the resident's lip, to left side of face by his to the resident's nose ers by 1.7 centimeters brown in color. The eek bruise measured 4.6 ars and was yellow/green ent's left lower lip scab entimeters. LPN #1 started the investigation occurred, but he had note book and he was			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155764	B. WIN			08/24/2	011
			D. (/11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	87TH AVE		
	MILL HEALTH CAM	IPUS		l	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0226		evelop and implement					
SS=D	written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.						
		ation, record review, and	F0	226	Facility completed investig	ation	09/23/2011
		cility failed to follow			on Resident B and notified IS		
	·	nvestigating injuries of			at the time of survey. There		
		and failed to notify ISDH			no negative outcome noted. residents are at risk for alleg		
	•	epartment of Health) of			deficiency. Investigations for	Ju	
	' '	of 4 residents reviewed			incidents of unknown origin v	vill	
					be reviewed for thoroughnes	s	
		known origin in a total			and appropriate notification t	0	
	sample of 4. (Re	esident B)			ISDH by DHS or designee.		
	Findings include	:	reporting will b accordingly.3.		Additional investigating and/oreporting will be completed accordingly.3. DHS or design		
	Resident B's reco	ord was reviewed on			will in-service nurses on investigation procedures per		
		p.m. Resident B's			facility policy and state repor	table	
	· ·	ed, but were not limited			guidelines. Nurses will be		
	_	pertension and anemia.			required to notify the		
	to, dementia, nyp	crension and anemia.			Administrator or designee of		
	A quarterly MDS	(Minimum Data Set)			situations requiring an incide report.4. DHS or designee w		
		d 8/5/11, indicated the			review investigations within 2		
	, , , , , , , , , , , , , , , , , , ,				hours of the incident and rep		
	resident had seve	ere cognitive impairment.			ISDH accordingly. Trends wi		
		1			brought to monthly QA x 6		
		dent report, dated 8/16/11			months or until 100% compli	ance	
	· ·	cated "the resident was			is achieved. 5. 9/23/11		
		ing to nose, sides of					
	mouth, lip tearl	Describe Injuryskin tear					
	and bruise small	in size (indicated by					
	being circled)A	Additional Information					
	Resident was see	n with redness to nose					
	tip, both sides of	mouth and lip with skin					
	-	I." The Incident/Accident					
	investigation was						

010739

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE SU COMPLE	
		155764	A. BUII B. WIN			08/24/20	11
NAME OF F	DOLUBER OR GURNUER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER				87TH AVE		
SPRING	MILL HEALTH CAN	IPUS		MERRII	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	REGULATORT OR	LSC IDENTIFFING INFORMATION)		IAG	DEFICIENCE TY	-	DATE
	Resident B was a	phearwad on initial tour					
	Resident B was observed on initial tour with LPN #1 on 8/19/11 at 8:50 a.m., sitting in his wheelchair in the dining						
	_	s a scabbed area to the					
		ip on the left side and a					
		ellow in color to the					
	· ·	ext to his mouth. The tip					
		nose was brownish red in					
		idicated the resident had					
	bitten his lip and the yellow bruise to the						
	resident's face was new.						
	resident s idee w	35 116 11.					
	A "Change in Co	ndition Form," dated					
	_	d "7:15 aResident					
	•	of nose reddish/bruised					
	_	uth with red marks, lip					
		and extremely aggitated					
	(sic)" The follo	ow up assessments for					
	8/16/11 the 3-11	shift and 8/16/11 the					
	11-7 shift were b	lank and lacked					
	assessments. The	e last documentation of					
	an assessment wa	as dated 8/18/11 on the					
	7-3 shift. There	was a lack of					
	documentation of	f an assessment for the					
	11-7 shift on 8/1'	7/11 and the 3-11 and					
	11-7 shifts on 8/1	8/11.					
	_	iew on 8/19/11 at 1:24					
	-	cated an investigation					
		be done by the nurse on					
		e injuries were found.					
		e had seen the yellow					
	bruise on the resi	dent's face when she had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED	
		130.0.	B. WIN		DDRESS, CITY, STATE, ZIP CODE	"-	
NAME OF	PROVIDER OR SUPPLIEF	2		1	37TH AVE		
	MILL HEALTH CAN			L	LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
1710	+	nesday 8/17/11. She	+	1710			DITTE
		ident's son had come in					
		nd asked what happened.					
	on wednesday and asked what happened.						
	During an interv	iew on 8/19/11 at 1:55					
	p.m., the Director of Nurses (DON)						
	1 *	ould have to check with					
	LPN #1 for the is	nvestigation. She					
		restigation should have					
		dent report. The DON					
	indicated the areas should have been reported to ISDH and an investigation						
	started because of where the areas were						
	located.						
		observed on 8/19/11 at					
	_	LPN #1 present. LPN #1					
		eas to the resident's lip,					
		to left side of face by his					
		to the resident's nose					
		ters by 1.7 centimeters					
		brown in color. The					
		eek bruise measured 4.6					
	1 *	rs and was yellow/green					
	was 3.2 by 0.2 co	ent's left lower lip scab					
	was 3.2 by 0.2 co	CHUIHCUIS.					
	An undated facil	ity policy, titled "Abuse					
		cedural Guidelines",					
	_	e Administrator on					
		n., as current, indicated					
	"The Executive						
	Director of Heal						
		he implementation and					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155764	B. WING			08/24/2	011
			P		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			101 W 8	87TH AVE		
	MILL HEALTH CAM	1PUS	MERRILLVILLE, IN46410				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ing of abuse standards					
	-	Injuries of unknown					
		n injury that occurs when					
	both of the following conditions are met: i. The source of the injury is not observed						
	by any person or	the source of the injury					
	could not be exp	lained by the resident					
	AND ii. The inju	ury is suspicious in nature					
	because of the ex	stent of the injury or the					
	location of the in	jurythe injury is					
	located in an area not generally vulnerable						
		Executive Director is					
		Notification to the State					
	-	ealthInvestigationthe					
	•	or is accountable for					
	investigating and						
	mivestigating and	reporting					
	This federal tag t	relates to Complaint					
	IN00094788.	clates to Complaint					
	11100054700.						
	3.1-28(a)						
	3.1 2 0(a)						
F0323	-	nsure that the resident ins as free of accident					
SS=D		sible; and each resident					
	· ·	supervision and assistance					
	devices to prevent						
	Based on record	review and interview, the	F0:	323	1. Residents D and E were n	-	09/23/2011
	facility failed to	ensure interventions were			longer at skilled facility at the		
	· ·	prevent further falls for 2			of this deficiency. There were negative outcomes noted.2.		
	of 3 residents wi	th falls in a total sample			residents at risk for falls are		
		•			risk for alleged deficiency. Al		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	COMPL		
AND PLAN	OF CORRECTION	155764	A. BUI	LDING	00	08/24/2	
133704		B. WIN	_		06/24/2	011	
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
000000		10.10		1	B7TH AVE		
SPRING	MILL HEALTH CAM	IPUS		MERKIL	LVILLE, IN46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		,	-	TAG			DATE
TAG	of 4. (Residents In Findings included 1. Resident D's resident D's resident D's resident particulated, but we dementia, cervice pneumonia. An admission M assessment, dated resident had sever required extensive two staff members use. The resident incontinent of both not on a toileting of the continence of the continence of the continence process of the c	ecord was reviewed on Resident D's diagnoses re not limited to, al spine fracture, and DS (Minimum Data Set) d 6/12/11, indicated the ere cognitive impairment, we assistance of one to rs for transfers and toilet at was frequently owel and bladder and was a program. d 6/3/11, indicated Check and change with (as needed)Wear duct at all times" d 6/3/11, indicated "Falls fury AEB (as evidenced lslow bed position. olerAppropriate 1 bed alarm6/29/11		TAG	current residents identified a risks will have interventions reviewed for effectiveness b DHS or designee. Interventi will be updated accordingly. DHS or designee will in-servent nurses on interventions to p further falls per facility policy residents will be assessed for risk upon admission. Nurses report to on-call nurse or designee any resident who had appropriate intervention be put in place. Incident reports will be reviewed by I or designee as they are completed for appropriate interventions. Indicent report rends will be reviewed mon QA meeting.5. 9/23/11	as fall y ons 3. vice revent v.4. All or fall s will falls owill DHS	DATE
	circumstance"						
	1	ated 6/29/11 at 9:15 p.m.,					
	indicated "RN fir	nds patient on floor next					

010739

 155764		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
		A. BUILDING 00			COMPLETED 08/24/2011		
100701			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/20	,,,
NAME OF F	PROVIDER OR SUPPLIER				87TH AVE		
SPRING	MILL HEALTH CAM	IPUS		1	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		tinent of stool. 4 cm	+	IAU			DATE
		by) 1.5 cm hematoma to					
	` ' '	notedpatient assisted					
	back to bed c (wi	•					
		till) two usbist					
	A fall circumstan	ice, assessment and					
	intervention form						
		v intervention put into					
		dent's fall was defined					
	parameter mattre	ss. There was a lack of					
	documentation to	indicate any new					
	interventions rela	ated to the resident's					
	incontinence.						
	The resident's fel	ll care plan, dated, 6/3/11,					
		v intervention of a bolster					
		n added on 6/29/11.					
	mattress nad been	in added on 0/29/11.					
	A fall circumstan	ace, assessment and					
		n, dated 7/5/11, indicated					
		been found on the floor					
		room in the bathroom					
		esident had an abrasion to					
		s forehead. The activity					
		fall was "transferring					
	_	and "ambulation." The					
		ne "prevention update"					
	_	nstance." There was a tation to indicate the					
	been addressed.	t to toilet himself had					
	ocen addressed.						
	 During an intervi	iew on 8/22/11 at 9:36					
	_	(Assistant Director of					
	, 112 311	(

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLET						
	155764		B. WING 08/24/2011					
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF I	KOVIDEK OK SOLI EIEK			1	87TH AVE			
SPRING	MILL HEALTH CAN	1PUS		MERRI	LLVILLE, IN46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	l ′	d a "Sleep Circumstance"						
		nelp if the resident had to						
	use the restroom.							
	2. Resident E's r	record was reviewed on						
	8/22/11 at 11 a.m	n. Resident E's diagnoses						
	included, but we	re not limited to, diabetes						
	mellitus, hyperte	nsion, stroke, and						
	aphasia.							
	An admission M	DS assessment, dated						
	5/19/11, indicate	d the resident had severe						
	cognitive impairs	ment, required extensive						
	assistance of one	staff member for						
	transfers and toil	et use. The resident had						
	fallen since admi	ission to the facility.						
		•						
	The care area ass	sessment, dated 5/25/11,						
		d the resident had a fall						
	since admission.	The resident needed						
	extensive assista	nce with ADLS						
		ly living) had a stroke						
	`	The resident's risk						
		the resident took						
		igh blood pressure, and						
		tions, and had cognitive						
	J - 1	eted his safety and						
		facility was proceeding						
	to care plan.	racinty was proceeding						
	to care plan.							
	A care nlan date	d 5/15/11, indicated						
		fall/injury AEB history of						
		onsother break (sic)						
		ate /remind resident to						
	extenderseduca	ne /remma resident to						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
155764		B. WIN			08/24/2	011	
	PROVIDER OR SUPPLIER		•	101 W 8	ADDRESS, CITY, STATE, ZIP CODE		
	MILL HEALTH CAM			MERRIL	LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		e prior to ambulation.	-				BINE
	Appropriate foot	-					
	Tippropriate root						
	A fall circumstar	nce, assessment and					
	intervention forn						
	indicated at 10 p	.m. the resident slid out					
	_	nees. The "prevention					
	update" was "res	ident education." (The					
	resident had seve	ere cognitive impairment					
	as indicated on the	he admission MDS.)					
		dent investigation for the					
	· ·	ndicated the previous					
	_	ntion was "bed alarm."					
		ntion was "encourage					
		or help when he wants out					
	of bed"						
	A fall airgumatar	nce, assessment and					
		n, dated 7/4/11, indicated					
		resident was assisted to					
	•	esident's bathroom. The					
		ne resident had improper					
		wear. The "Prevention					
	1	d "Nonskid footwear."					
	T T T T T T T T T T T T T T T T T T T						
	An incident/acci	dent investigation for the					
		dicated "Resident was					
		I to toilet et (and) was					
	lowered to the flo	oor c (with) staff help.					
	When writer inve	estigated, resident was					
	sitting on the floo	or in front of toilet.					
	Resident said his	legs won't straighten.					
	Loose fitting soc	ks S (without) shoes					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155764		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE COMPI	LETED	
		B. WIN	G		08/24/2	2011	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			•	101 W 8	DDRESS, CITY, STATE, ZIP CODE 87TH AVE	•	
				<u> </u>	LVILLE, IN46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)			(X5) COMPLETION DATE
IAG	observedNew is stockings or shoot transferred." The appropriate footwood dated 5/15/11. An incident/accide fall on 7/11/11, in observed sitting or room bathroom of w/c (wheelchair) call light on reside helpResident stage to the bathroom was will add clip. The form indicate of "toilet resident was crossed out. A fall circumstant intervention form indicated at 6:40 found on the floot indicated the resident was crossed out. A fall circumstant intervention form indicated at 6:40 found on the floot indicated the resident was all chair alarm was all chair alarm had be intervention on 7.	experimental and the prevention was transferring ulating when he fell. The prevention update was alarm" The fall ted 6/16/11, indicated a ready in place and the prevention updace and the prevention updace and the prevention update was alarm"		IAG	DETRIENCY		DATE
	P.III., the corpora	To Harbe Combattunt					

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Event ID:

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Facility ID:

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
155764		B. WING		08/24/2011		
NAME OF B	ADOLUDED OD GUDDU IED			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		101 W	87TH AVE		
	MILL HEALTH CAM			ILLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
1/10		ident should have had on	1710		DATE	
		when the fall occurred on				
		cated encouraging a or assistance was not an				
		vention for a resident				
	_	npairment. The nurse ted the bed alarm had				
	aiready been in p	blace back in June.				
	Tl.:- C. 1 1 4	orlates to Communicat				
	_	relates to Complaint				
	IN00094788.					
	2.1.45(.)(2)					
	3.1-45(a)(2)					
	•					
F0514	The facility must m	naintain clinical records on		i		
SS=D	•	ccordance with accepted				
00 5		lards and practices that are				
		ely documented; readily				
	accessible; and sy	stematically organized.				
	The clinical record	l must contain sufficient				
	information to ider	ntify the resident; a record of				
		essments; the plan of care				
		ded; the results of any				
	State; and progres	ening conducted by the				
		ation, record review, and	F0514	1. Facility completed investig	gation 09/23/2011	
		cility failed to ensure a		on Resident B and notified IS		
	f f	was complete and		at the time of survey. There	•	
		to assessments and an		no negative outcome noted.2	•	
	accurate related t	w assessments and an		residents are at risk for alleg	eu	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLI	COMPLETED	
	I 155764		B. WIN			08/24/20	011
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			101 W 8	87TH AVE		
	MILL HEALTH CAN	IPUS			LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	,	-	DATE
	_	injuries of unknown			deficiency. Investigations for incidents of unknown origin v		
	~	residents reviewed for			be reviewed for thoroughnes		
	"	own origin in a total			and appropriate notification t		
	sample of 4. (Res	sident B)			ISDH by DHS or designee.		
	Findings include				Additional investigating and/oreporting will be completed accordingly.3. DHS or design will in-service nurses on		
	Resident B's reco	ord was reviewed on			investigation procedures per		
	8/19/11 at 12:45	p.m. Resident B's			facility policy and state repor	table	
	diagnoses includ	ed, but were not limited			guidelines. Nurses will be		
	to, dementia, hyp	pertension and anemia.			required to notify the Administrator or designee of		
					situations requiring an incide		
	A quarterly MDS	S (Minimum Data Set)			report.4. DHS or designee w		
		d 8/5/11, indicated the			review investigations within 24		
	l '	ere cognitive impairment.			hours of the incident and report to		
					ISDH accordingly. Trends will be brought to monthly QA x 6	li be	
	at 7:00 a.m., indi found with bruisi mouth, lip tear	dent report, dated 8/16/11 cated "the resident was ing to nose, sides of Describe Injuryskin tear			months or until 100% complisis achieved.		
		in size (indicated by					
		Additional Information					
		n with redness to nose					
	1 * :	mouth and lip with skin					
	• •	I." The Incident/Accident					
	investigation was	s left blank.					
	Resident B was o	observed on initial tour					
	with LPN #1 on	8/19/11 at 8:50 a.m.,					
	sitting in his whe	elchair in the dining					
	room. There was	s a scabbed area to the					
	resident's lower l	ip on the left side and a					
		ellow in color to the					
		ext to his mouth. The tip					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155764		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	` ′	e survey Pleted 1/2011	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STRE 101	EET ADDRESS, CITY, STATE, W 87TH AVE RRILLVILLE, IN46410	ZIP CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
mo	of the resident's recolor. LPN #1 in	nose was brownish red in adicated the resident had the yellow bruise to the	ING.			BAIL
	8/16/11, indicate was seen with tip both sides of more reddish skin tear (sic)" The follow 8/16/11 for the 3-the 11-7 shift we assessments. The an assessment was 7-3 shift. There documentation o	f an assessment for the 7/11 and for the 3-11 and				
	p.m., RN #2 indi was supposed to 8/16/11 when the She indicated she	ew on 8/19/11 at 1:24 cated an investigation be done by the nurse on injuries were found. The had seen the yellow dent's face when she had esday 8/17/11.				
	p.m., the Directo indicated she wo LPN #1 for the in	ew on 8/19/11 at 1:55 r of Nurses (DON) uld have to check with exestigation. She estigation should have ent report.				

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Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155764		(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE S COMPL 08/24/2	ETED	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STF 10	1 W 8	DDRESS, CITY, STATE, ZIP CODE 7TH AVE LVILLE, IN46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	2:10 p.m., with I measured the are nose, and bruise mouth. The area was 1.8 centimet and was reddish/resident's left che by 1.7 centimeter color. The reside was 3.2 by 0.2 ce indicated he had of how the areas documented in a unable to find the	observed on 8/19/11 at a complete the resident's lip, to left side of face by his to the resident's nose ers by 1.7 centimeters brown in color. The each bruise measured 4.6 ars and was yellow/green ent's left lower lip scab entimeters. LPN #1 started the investigation occurred, but he had note book and he was enote book. The relates to Complaint					